FORM B10 (3/98)

United States Bankruptcy Court
District of Idaho

Complete this form and mail to: U.S. Bankruptcy Court 550 W.Fort St. Boise, ID 83724

PROOF OF CLAIM
THIS SPACE IF FOR COURT USE ONLY

U.S. COURT
2001 JAN 10 AM 8 06

Name of Debtor: DAVID + KIMBERLY JENNINGS

Case Number: 97-24686

Chapter: 13 **Trustee:**

Proof of claim form and all supporting documents must be filed in **DUPLICATE** on Chapter 12 and 13 cases

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to U.S.C. §503

Name of Creditor (The person or other entity to whom the debtor owes money or property):
HOLY ROSARY MEDICAL CENTER
351 W. 9TH STREET
ONTARIO, OR 97914

- ☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
- ☐ Check box if you have never received any notices from the bankruptcy court in this case.
- ☐ Check box if the address differs from the address on the envelope.

Account or other number by which identifies debtor: SEE ATTACHED STATEMENTS

Check here if this claim: ☐ Replaces ☐ Amends a previously filed claim dated:

1. Basis for Claim ☐ Goods Sold ☒ Services Performed ☐ Money Loaned ☐ Personal Injury/Wrongful Death ☐ Taxes
☐ Retiree benefits as defined in 11 U.S.C. §1114(a) ☐ Other (please describe)
☐ Wages, Salaries and compensation: Your Social Security Number: _____
☐ Unpaid Compensation for services performed from _____ (date) to _____ (date)

2. Date debt was incurred: SEE ATTACHED STATEMENTS

3. If court Judgment, date obtained:

4. SECURED CLAIM
☐ Check box if your claim is secured by collateral (including a right of setoff)
Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
☐ Other _____
Value of Collateral $ _____
Amount of arrearage and other charges *at time the case was filed* included in secured claim, if any:
$ _____

5. UNSECURED PRIORITY CLAIM
☐ Check box if you have an unsecured priority claim
Amount entitled to priority $ _____
SPECIFY PRIORITY OF CLAIM:
☐ Wages, Salaries, or commissions (up to $4000)* earned within 90 days before filing of the bankruptcy petition or cessation or the debtor's business, whichever is earlier. (11 U.S.C. § 507 (a)(3))
☐ Contributions to an employee benefit plan (11 U.S.C. § 507 (a)(4))
☐ Up to $1,800* of deposits toward purchase, lease, or rental of property or services for personal, family or household use (11 U.S.C. § 507 (a)(6))
☐ Alimony, maintenance, or support owed to a spouse, former spouse or child (11 U.S.C. § 507 (a)(7))
☐ Taxes or penalties owed to governmental units (11 U.S.C. § 507 (a)(8))
☐ Other - Specify applicable paragraph of (11 U.S.C. § 507 (a)( )

**Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. TOTAL AMOUNT OF CLAIM AT TIME CASE WAS FILED
UNSECURED $ 442.47 SECURED $ _____
PRIORITY $ _____ TOTAL $ _____
☐ Check box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all additional charges.

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.
8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, please explain. If the documents are voluminous, attach a summary.
9. Date Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

DATE: 1/8/01

Sign and print the name and title, if any of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)
HOLY ROSARY MEDICAL CENTER
S. OTTEM

Penalty for presenting fraudulent claim: Fine up to $500,000 or imprisonment for up to 5 year, or both. 18 U.S.C.§152 and §3571

CATHOLIC HEALTH INITIATIVES

Holy Rosary Medical Center

PATIENT	PT TYPE
ENNINGS,KIMBERLY M	ECU

ACCOUNT NUMBER	DATE ADMITTED	DATE DISCHARGED
9913100097	05/11/99	05/11/99

BILL DATE 05/15/99

STMT TYPE D1 BILLER 35

☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NO. _____ EXP. DATE _____

SIGNATURE _____ PAYMENT AMOUNT $ _____

GUARANTOR:

KIMBERLY M JENNINGS
1865 CENTER AVE APT 5
PAYETTE ID 83661

HOLY ROSARY MEDICAL CENTER
DEPARTMENT 589
PO BOX 34935
SEATTLE WA 98124-1935
1-541-881-7066

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

SERVICE DATE	UB92 REV	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
			272 STERILE SUPPLY			19.41
			300 LABORATORY			121.06
			402 ULTRASOUND			120.00
			450 EMERG ROOM			100.00
			981 PRO FEE/ ER			82.00
			TOTAL CHARGES			442.47
			TOTAL PAYMENTS/ADJUSTMENTS			0.00

NOTE: THIS BALANCE DOES NOT INCLUDE PROFESSIONAL CHARGES FOR PHYSICIANS SUCH AS ANESTHESIOLOGISTS, RADIOLOGISTS, PATHOLOGISTS AND CARDIOLOGISTS. YOU WILL RECEIVE A SEPARATE BILL DIRECTLY FROM THE PHYSICIAN FOR THOSE SERVICES.

ACCOUNT BALANCE 442.47

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STATEMENT OF ACCOUNT

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